

For the month of:	
Date completed	

INSTRUCTIONS TO CASEWORKER: This form must be completed accurately and legibly. Prescription medication must be clearly identified.

Recipient's name		Names of others whose incurred medical expenses are allowed:
Case number (Case / Cat. / Seq.)	RID	

Subtract third party payments  Amount Medicaid can pay  Amount Medicaid can pay								
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## LOG OF INCURRED MEDICAL EXPENSES

State Form 11131(R2 / 2-96) / FI 0008

SERVICE PROVIDER SERVICE THIRD PARTY PAYMENT  \$	NAME	DATE OF	NAME OF	TYPE OF	AMOUNT	VERIFICATION
	IVAIVIE	SERVICE	PROVIDER	SERVICE	THIRD PARTY PAYMENT	VERIFICATION
					\$	